STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115452	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Shepherd Hills	800 Patterson Rd LA Fayette, GA 30728

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policies titled, Infection Prevention-Hand Hygiene and Infection Control-Linen and Laundry, the facility failed to ensure that staff consistently followed appropriate hand hygiene and sanitation practices. Specifically, staff failed to perform hand hygiene and sanitize surfaces during wound care for 1 of 14 residents (R)(R51) and failed to perform hand hygiene between resident contacts. These deficient practices placed residents at increased risk for infection transmission and cross-contamination.Findings include:Review of the facility's policy titled Infection Prevention-Hand Hygiene revised 10/15/2024 revealed under section D. Indications Requiring Hand Wash or Hand Rub, number 5. After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, and wound dressings.Review of the facility's skills competency checklist for Wound Care Treatment, undated, under title, Dressing Change, Step 1. Loosen tape or adhesive borders pulling toward the dressing while supporting the peri (around) wound skin.Remove gloves, perform hand hygiene, and apply clean gloves.Review of the facility's policy titled Infection Control-Linen and Laundry revised 11/30/2023 under section E. Storage number 1. Clean laundry should be handled as little as possible and should be covered before being stored.Review of the electronic medical record (EMR) revealed R51 was admitted to the facility with pertinent diagnoses including, but not limited to, type 2 diabetes mellitus with hyperglycemia, peripheral vascular disease, atherosclerotic heart disease, congestive heart failure, and the presence of a suprapubic catheter.Review of R51 significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicates R51 has moderate cognitive impairment.Review of R51's care plan dated 5/28/2024 indicated a problem of risk for skin breakdown related to impaired mobility, incontinence, the presence of a suprapubic catheter, and a wound to the right ankle first documented on 6/19/2025. Goals included, but were not limited to, the resident not acquiring any staged pressure injuries through the next review period. Interventions included providing incontinence care every shift, applying barrier cream as indicated, keeping the skin clean and dry, reporting any signs of skin breakdown, and completing wound and catheter care per physician orders. Additional approaches included zinc oxide application to the buttocks, wound treatment to the right ankle, and consultation with the Quality Skin Management (QSM) team as indicated.Review of the Physician's Orders for R51 included but was not limited to:Order dated 8/20/2025 for treatment to the right ankle wound. Instructions were to cleanse the wound with wound cleanser, pat dry, apply skin prep to the peri-wound borders, apply honey to the wound bed, and cover with an adhesive foam bandage. Frequency: Once daily on Monday, Wednesday, and Friday between 7:00 am and 7:00 pm.Order dated 8/20/2025 for PRN (as needed) wound care to the right ankle with the same treatment procedure as noted above, to be used for dressing changes outside the scheduled days as needed.Observation on 10/1/2025 at 1:51 pm of the facility's laundry area revealed that clean linens were stored on multiple open shelves; however, they were not adequately protected from potential contamination. Items such as towels, washcloths, and blankets were organized on three separate shelves. These same shelves also contained various staff personal items in direct contact with the clean linens, including: a disposable Styrofoam cup, a reusable water (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	bottle, a plastic water bottle in a cozy, a plastic bag containing soda bottles and miscellaneous items, loose papers, a clock, office supplies (e.g., scissors), and a box of additional office-related items.Interview on 10/1/2025 at 2:11 pm with Housekeeping Supervisor II revealed uncertainty regarding what items were permitted to be stored on the same shelves as clean linens. She acknowledged that personal items likely should not be stored there, as they were not considered clean. She stated she would ensure all non-linen items were removed from the shelves to prevent contact and potential contamination.Observation on 10/1/2025 at 2:21 pm revealed Licensed Practical Nurse (LPN) EE performing wound care for Resident (R) (R51). During the procedure, LPN EE failed to remove her gloves and perform hand hygiene after removing and discarding the soiled dressing and prior to cleansing the wound.Interview on 10/1/2025 at 2:32 pm with LPN EE confirmed and acknowledged she did not remove her gloves after disposing of the soiled dressing. She stated that she believed it was not necessary to change gloves at that point because she was still working with the dirty area. This rationale was confirmed twice during the interview.Interview on 10/1/2025 at 5:36 pm with the Director of Nursing (DON) revealed that she was unable to answer questions related to infection control practices and referred the surveyor to the facility's Infection Preventionist.Interview on 10/1/2025 at 5:50 pm with the Infection Preventionist (IP) revealed that clean linen must not be stored on shelves with any other items, particularly personal belongings, as this results in contamination. She emphasized that such practices require the linens to be rewashed, creating unnecessary workload and increasing the risk of infection for immunocompromised residents. The IP stated she would begin including the laundry area in her routine rounds and would provide additional infection control education to laundry staff, including the supervisor.Interview on 10/2/2025 at 11:09 am with LPN FF, Skin Integrity Nurse Manager, revealed that after removing a soiled dressing, standard practice requires the nurse to remove gloves, perform hand hygiene, and don (put on) clean gloves before proceeding with wound cleansing. She stated that failure to follow this protocol increases the risk of cross-contamination. In a follow-up interview at 1:32 pm, LPN FF added that even touching the outer surface of a soiled dressing can introduce bacteria, which may lead to infection, the need for antibiotics, and further deterioration of the wound. She confirmed that she personally assessed the resident and initiated orders to monitor for signs and symptoms of infection for the next 10 days.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and review of the facility policy titled, Freedom from Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property Mission Statement, the facility failed to report physical abuse by staff to the State Survey Agency (SSA) within the required timeframe for one of six sampled residents (R) (R21) reviewed for abuse and neglect. The failure of the facility to report this incident has the likelihood of leading to future unreported injuries of unknown origin, with the potential to affect resident's quality of life.Findings include: Review of the policy titled Freedom from Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property Mission Statement revised 112/1/2016, revealed the policy of the facility to notified the state survey agency in accordance with state law through established procedures of any allegations of abuse, neglect, exploitation or mistreatment, including injuries of any unknown source an misappropriation of patient property, within 2 hours after the allegation is made of the events upon which the allegation is based involve abuse or result in serious bodily injury, and not later than 24 hours if the events upon which the allegation is base4d do not involve abuse and do not result in serious bodily injury. Review of R21's electronic medical record (EMR) admission Record under the MDS tab revealed R32 was admitted to the facility on [DATE] with diagnoses that included but not limited to, dementia with other behavioral disturbances and depression. The resident's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed his Brief Interview for Mental Status (BIMS) was not coded, indicating cognition could not be determined, due to resident is rarely/never understood. R21 is totally dependent on staff for toileting hygiene, personal hygiene. Review of Facility Incident Report Form (FRI) dated 4/11/2025 documented the type of abuse as staff to a resident. Review of the Five-Day follow-up summarized the details of the incident: on 4/11/2025 it was reported to the Unit Manager that R21 became combative and argumentative during peri-care and CNA DD put the wipe with bowel movement to R21's face. CNA DD was immediately suspended pending investigation. Medical Director (MD), Police department, and Responsible Party notified. Facility investigation initiated.The investigation reflects reported incident that occurred on 4/7/2025 and was witnessed by CNA NN. The Director of Health Services (DHS) CNA NN regarding the incident. CNA NN verbalized she did witness the incident. CNA NN reported she was surprised by what she had witnessed and immediately told CNA DD she could not do that and told her to leave the room, and she would finish providing care to R21. CNA NN reported that she cleaned R21's face and finished providing care. CAN NN reported due to CNA's DD reaction to the situation and prior experiences with CNA DD interactions with herself and other CNAs she was afraid of what CNA DD would do if she mentioned the incident. One on one education was provided to CNA NN regarding Recognizing and Reporting Abuse and the process that follows a report of abuse, online education was assigned to CNA NN for Recognizing and Reporting Abuse, a final written warning was given to CNA NN with the expectation of reporting abuse immediately, any further violation of not reporting abuse immediately will result in immediate termination.CNA DD was terminated as a result of the investigation. Review of R21's progress note from 4/11/2025 revealed: This nurse was made aware of allegations of abuse to resident by a staff member. Resident has no signs of distress noted at this time. Abuse coordinator made aware. [NAME] PD made aware. R21's made aware. NP made aware. Report number 2025-00002328. Interview with DHS on 10/02/25 at 11:40 pm revealed that CNA DD was employed at this facility from October of 2021 to April 2024, and did not have any disciplinary auctions, and no complaints from residents.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on records review and staff interviews, the facility failed to ensure accurate Minimum Data Set (MDS) assessment for one of 40 sampled residents (R) (R21). Specifically, the facility failed to accurately code Section P (Restraints and Alarms) for R21. The deficient practice resulted in not accurately representing R21's health status. Findings include:Review of R21's electronic medical record (EMR) admission Record under the MDS tab revealed R21 was admitted to the facility with diagnoses that included but not limited to, dementia with other behavioral disturbances and depression.Review of the quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/27/2025 indicated R21 does not use wander/elopement alarm.Review of the quarterly MDS with an Assessment Reference Date (ARD) of 6/21/2025 indicated R21 does not use Wander/elopement alarm.Review of current physician orders for R21 included but not limited to:Wander guard placed on left wrist-check functioning daily, start date 11/13/2024.Wander guard placed on left wrist-check placement q (every) shift, start date 11/13/2024.Review of a care plan with last reviewed/revised date of 7/8/2025 for R21 revealed Problem: risk for elopement as evidenced by exit seeking behavior. Approaches included but not limited to: Check wander guard devise for proper functioning and placement per facility protocol or manufacture's recommendations.Interview with the MDS Director on 10/2/2025 at 11:35 am confirmed that R21 wore a wander guard bracelet on her left wrist and it should be reflected on the MDS assessment. The MDS Director confirmed that quarterly assessment from 6/21/2025, section P was coded incorrectly, and she would reopen it and would make corrections.Interview with Director of Health Services (DHS) on 10/2/2025 at 11:50 am revealed that the previous MDS Director resigned a few months ago, and the facility had a new MDS Director. She stated that the MDS assessment should reflect resident's wander guard use.Interview with the Administrator on 10/2/2025 at 1:25 pm revealed that the facility did not have an MDS assessment policy, and they followed the Resident Assessment Instrument (RAI) Manual.